THE DIABETIC SUPPORT NETWORK

The Diabetic Division of The National Federation of the Blind

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ON THE LAUNCHING OF A NEW DIVISION

by Dr. Kenneth Jernigan, President
The National Federation of the Blind

The launching of a new publication is always a momentus occasion. It leads one to examine the past and speculate about the future.

When Ed Bryant asked me to write something for this initial issue of the newsletter of the Diabetic Division of the National Federation of the Blind, I engaged in the conventional mindsearch, looking backward and looking forward to see whether I could find anything worth saying; and I am still not sure whether the answer is yes or no. Certainly the occasion deserves recognition and comment, for what the Diabetic Division is attempting will (either by its success or its lack of success) have a significant impact on the lives of the nation's blind.

Diabetes (as everyone knows) is now a leading cause of blindness in this country. There is every prospect that this will continue to be the case for decades to come. If the diabetic who becomes blind is to have real opportunity and a meaningful life, it is the Division and this newsletter which must point the way and help make it happen. The responsibility is that encompassing and that imperative.

Moreover, the people who have come together to form the Division cannot now (even if they would) avoid personal accountability. It is one thing not to know what is happening. It is something else to know and refuse to participate. It is still something else to know, to choose to participate, and to take positive steps to help launch an enterprise. After that, there is no returning, no going back to the days before.

So it is with you who have formed the Diabetic Division of the National Federation of the Blind. You have recognized a need (your own as well as that of others), and you have stood forth to be counted. You have said that 1985 will be the continental divide in the affairs and lives of blind diabetics--and I emphasize that I am talking about you, not just others. If this Division does its work imaginatively, effectively, and conscientiously, no blind diabetic will ever have the same kind of life in post 1985 that he or she would have had before. So I repeat that the launching of this newsletter is an event not only of substantial but also of symbolic significance. It signals the beginning of a new era for the blind diabetic.

What does this mean for the rest of us in the Federation, those who are blind (or, for that matter, not blind) but who are not diabetic? It is important for us, too. With the coming of the Diabetic Division a gap in our range of activities and awareness is closed. A subtle realignment of balances and shifting of emphasis is achieved, for nothing can affect a major segment of the blind population without impacting upon us all--and certainly the diabetics constitute a major segment of our population. It will be the responsibility (and, yes, the pleasure) of the rest of us in the movement to support and encourage your Division--to learn from you (and through you) to reach out to blind diabetics who have either not known about us or not known enough about us to realize the vital importance to them of joining the movement and taking an active part in its programs.

In turn, you have a responsibility to the rest of us in the movement--to the blind as a group, to those who are not diabetic. You must find the diabetic who is newly blind and help him or her understand that it is not enough to cope with the medical aspects of blindness and diabetes. Unless there can be an improvement in public attitudes and, indeed, an evolution of our own abilities, there can never be full life and equal citizenship. As deadly as is the imbalance of insulin, it is no more deadly than the imbalance in society's perception and treatment of the blind. Each (if unchecked) will destroy you, and in either case the destruction will be slow, not always easy to recognize, and viciously insidious.

An important truth which some ignore and many have never learned is the fact that the blind as a group have common interests, which can only be addressed collectively--in our capacity as a group and not as individuals. To those who do not believe this or do not know what it means, I can only say: Read our literature; attend our meetings. You will understand.

May the Diabetic Division of the National Federation of the Blind accomplish the purposes for which it was established. May it grow and flourish--and may this newsletter be its voice, its call to conscience and its symbol of hope for the blind diabetic. What you have undertaken in launching your venture is this compelling and this significant.

NEWSLETTER NAME NEEDED - $100 PRIZE

We are the Diabetic Division of the National Federation of the Blind. Our inception was accomplished at the NFB national convention in Louisville, KY.

We are looking for a name for our fledgeling newsletter. I encourage you to send me a suggestion for a name. Names will be given to a committee at our 1986 national convention. The committee will select the best name and the name will be matched up with the person who sent it. The winner will receive a prize of $100.00.

The only requirement is that the newsletter name must include the word "Diabetic". Names should be sent to the editor: **Ed Bryant; Vice-President, NFB Diabetic Division, 111-A Stadium Blvd. N., Columbia, MO 65203 (314) 445-1928.**

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"ARE YOUR EYES OPEN??"

by Joyce Miller

In 1973 I went totally blind from my diabetes. By 1974 my eyes were completely closed. This was due to shrinkage and dehydration of my eyeballs. People acted like I was not in the room. If I went with a friend to a business the receptionist would always talk to my friend and ignore me. If I was sitting in a room with people nobody would say a word to me unless I spoke first. This lasted for ten years.

I had numerous illnesses during this time. I was under the care of nine different kinds of specialists. None of them ever told me about scleral shells or prosthetic eyes. In 1984 Ed Bryant told me about these wonderful eyes (Praise the Lord!). I went to Kansas City, MO to an eye doctor. He told me where I could get my eyes. Scleral shells would have cost me several hundred dollars I did not have. I telephoned Dr. Kenneth Jernigan, President of the National Federation of the Blind (NFB) in Baltimore, MD. Dr. Jernigan and NFB were able to assist me financially and I will never be able to thank them enough. I got my eyes at Mager and Googlemann, Ocularists, in Kansas City, MO.

The doctor I have now didn't know anything about prosthetic eyes until I got mine. I wonder what my doctors thought about my closed eyes. Did they think I did not care what I looked like because I could not see myself? Maybe they didn't think anything about it at all. Whatever the reason our doctors must be educated about this. NFB has all kinds of literature dealing with blindness.

EDITOR'S COMMENTS: Joyce is a young, adult, single woman with the same desires and expectations that most people have. She is a sociable person and wants to actively participate in various social events. I can vividly recall when I made Joyce aware of the possibility of prosthetic shells. She was ecstatic to know that after years of not being able to open her eyes she would be able to have her eyes open like everybody else.

If the eyeballs dehydrate enough then the eyelids will close and there is no way they can be opened. The normal outward protrusion of the eyeballs allows the eyes or the eyelids to open. Your ophthalmologist should be one who specializes in retinal problems. This will not guarantee that he will know about the prosthetic shell, however he probably will. Not all people can wear the shell but many can.

Joyce is definitely correct in that we need to educate physicians in many areas pertaining to blindness. In Joyce's case, she wanted to be involved and converse with people in different social settings. It is a matter of pride and self-esteem that an adult be treated as such and not be ignored.

Most people do not understand that blind people just happen to be blind and want and deserve to be treated like everybody else. Many people are uncomfortable around a blind person because they do not understand. However, in Joyce's case, she spent 24 hours a day with her eyes closed. It seems obvious to me that people might be uncomfortable talking to anyone who had his eyes totally closed during the entire conversation. I have to ask myself why didn't at least one of Joyce's doctors inquire about her eyes being closed and make positive suggestions? She had several highly specialized physicians who I suspect see many people with prosthetic eyes.

I know that many people need education about blindness but I guess what I wonder is, could it be that none of Joyce's many doctors knew anything about prosthetic eyes or could it be that because she was blind they didn't think it would matter if her eyes were open or not?
I WONDER - - I JUST WONDER!

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IN THE BEGINNING.....

The N.F.B. Diabetic Division concept originated with two federationists, Karen Mayry, Rapid City, SD, and Eileen O'Brian, Elmhurst, IL. Both had become diabetics as children, lost their eyesight due to their diabetes and had received kidney transplants. They felt a need to inform other diabetics experiencing the ramifications of the disease, that they had options and could continue to live productive lives. Neither their diabetes, their blindness nor their renal failure need stop them.

Since its inception in 1982, the diabetics in the National Federation of the Blind have chosen to expand their horizons. Members have not only experienced blindness and renal failure, but strokes, amputations, neuropathy, heart attacks and much more. Thus, they have the expertise to support others through letters, telephone calls and meetings. Individuals who have knowledge in any of those areas have committed themselves to aiding others facing similar experiences. Often persons in the medical profession do not have the time nor the first-hand knowledge of the diabetic who has had a stroke, kidney transplant or amputation. The N.F.B. Diabetic Division can supply that knowledge.

As we go to press, the diabetic support network is growing. More than 100 persons nationwide currently support their fellow diabetics through the N.F.B. Diabetic Division. Questions regarding aids and appliances used by diabetics for continued independence and dealing with the ramifications of diabetes are willingly answered by Division members. Interested persons may also contact: **Karen S. Mayry, President; N.F.B. Diabetic Division; 919 Main/Suite 15; Rapid City, SD 57701**

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OUR NEWSLETTER/OUR DIVISION

by Ed Bryant

I am an insulin dependent type one diabetic. I have had early onset diabetes, also called juvenile diabetes since the age of 14, some 27 years ago. I have undergone renal failure and diabetic retinopathy. Over two years ago I had a very successful kidney transplant which to date is working perfectly. I find blindness to be a nuisance but no more than that. I am not a less capable person because I happen to be blind. I have been entrusted with the responsibility of serving as editor of this quarterly newsletter. This means hard work and challenges which I think are always good.

Currently the only problem I have with the newsletter is a lack of material. This problem can easily be remedied by each of you being a part of the team and supplying me with needed information. My experience in journalism is miniscule, as perhaps yours is, but is increasing substantially as you give me advice and comments.

There are a few moments in a life time that might be permanently etched in one's memory. Tell us your stories, humorous or serious, about life and diabetes, in your own words. It is both therapeutic for you to tell them and productive for us to print them, either publicly or anonymously.

Articles from non-diabetic sources such as family members and other interested parties are also most enjoyed. For future editions I hope to be bombarded with information on diabetes. There is definitely a place for stories from diabetics who have had no major problems and from loved ones who live with a diabetic.

Please don't be reluctant to supply me with comments and stories. Most of us are lay persons and perhaps writing is not your "cup of tea." I will see to it that errors in submitted material are corrected. I can guarantee that if corrections are needed the only people who will ever know this will be you and your editor's pen. For further submission guidelines, please write to me, Ed Bryant.

We are the Diabetic Division of the National Federation of the Blind(NFB). Our inception as a division was accomplished at the NFB 1985 National Convention in Louisville, KY.

The greater mission of the NFB is to serve all blind people whatever the cause of blindness. NFB is an organization of well over 50,000 members with affiliates in every state. We must be cognizant of the fact that diabetes is the leading cause of new blindness in America. We must keep things in perspective, as there is more discrimination against the blind than against people who have undergone any other complication of diabetes. The specific mission of the diabetic division is to offer support, knowledge and assistance to all diabetics. Our membership is most certainly not only composed of blind and visually impaired people. Our goal is to reach all diabetics. Our doors are open to all interested parties. We shall stay abreast of the effects of diabetes and the current status of diabetes research.

All people should have pride and a sense of self-worth. More poignantly if they desire and are able they should be allowed to be productive contributing members of society.

This publication is being circulated nationally, disseminating much information. If you are a physician, diabetic educator, or an agency receiving this newsletter I would ask that you make all diabetics and other interested parties aware of the Diabetic Division of the NFB. We are willing and able to make presentations to any group desirous of knowing more about our organization. Much fear and trepidation can be avoided or minimized by utilization of our experience and expertise in diabetes. Since many of our members are blind and visually impaired we are called on frequently to assist the blind diabetic in independent living techniques.

This newsletter is vital to your lifestyle. We can offer support, hope, and information presented as nowhere else. We are unique. We are not replacing the American Diabetes Association or the doctors who deal with diabetes. Our division serves an ever-growing number of people. We are a self-help organization and although many of us have faced ramifications of the disease, such as amputations, heart attacks, renal failure, blindness, strokes, etc., we do not consider these as handicaps. We exhibit a positive attitude which we feel is contagious. We are young and old alike, working together to solve and prevent mutual problems and concerns.

Our newsletter reflects the feelings of members and provides a place where their voice can be heard. Most of us realize that about 70% of our nation's blind and visually impaired persons are unemployed. This 70% includes many people who are desirous of being gainfully employed. Entailed in our philosophy is the absolute fact that all people need to be informed, educated, or enlightened about blindness.

It is imperative that money be spent expeditiously. The NFB has provided a small grant so that our division can get started and get on its feet. I can assure you that the $1.00 membership dues will neither pay the cost of producing this newsletter nor cover other divisional expenses. Total cost of this newsletter is at least $800/annum. Just as each of us is an important part of the Diabetic Division, our division is an integral part of the NFB. Like all divisions of the NFB we are expected to pay our own way. Please send any fund raising ideas you have to any of our Diabetic Division Board Members. If you are able and have it in your heart, please make whatever contribution you can and send it to our Treasurer, Carl Nimis.

If you wish to join our division, you are guaranteed anonymity. Your name will not be randomly given out as we do guarantee confidentiality.

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WHAT IS THE NATIONAL FEDERATION OF THE BLIND?

The NFB

The real problem of blindness is not the loss of eyesight. The real problem is the misunderstanding and lack of information which exist. If a blind person has proper training and opportunity, blindness is only a physical nuisance.

The National Federation of the Blind is the largest organization of the blind in America. Interested sighted persons also join. Founded in 1940, the Federation has grown to include more than ten percent of the nation's blind (over 50,000 members).

The Federation is organized in every state and has local chapters in almost every community of any size in the nation. Where there is no local chapter, there are members at large. Each year the National Convention of the Federation is attended by approximately 2,500 blind persons--the largest gathering of blind people in the history of the world and growing each year.

Purpose

The ultimate purpose of the National Federation of the Blind is the complete integration of the blind into society on a basis of equality. This objective involves the removal of legal, economic, and social discriminations; the education of the public to new concepts concerning blindness; and the achievement by all blind people of the right to exercise to the fullest their individual talents and capacities. It means the right of the blind to work along with their sighted neighbors in the professions, common callings, skilled trades, and regular occupations.

The Newly Blind

The newly blinded person faces a difficult adjustment. One of the best medicines is to meet other blind people and learn of their jobs and the techniques they use in doing things without sight. Membership in the NFB provides this common meeting ground and, even more importantly a sense of participation and restoration of confidence. Members of the NFB contact newly blinded persons to help them with problems of adjustment and orientation.

Information is also given concerning available services from governmental and private agencies, as well as facts about laws and regulations concerning the blind.

A Distinctive Role

The Federation corresponds to blind people in the same way that labor unions correspond to workers, the Chamber of Commerce to business people, the American Bar Association to lawyers, the NAACP to blacks, the American Medical Association to doctors, and the Farm Bureau to farmers. It is a vehicle for joint action by the blind. In other words, the National Federation of the Blind is the voice of the blind. It is the blind speaking for themselves.

Who Represents The Blind

There are numerous governmental agencies and private charitable organizations and foundations providing services for blind people, but only the blind themselves (acting through their own organization, the National Federation of the Blind) are able to speak for the blind. This is a basic concept of democracy.

The government has a Department of Labor, but it cannot truly speak for workers. They speak for themselves. Like the Department of Agriculture does not replace farm organizations, nor do governmental agencies or private foundations take the place of democratic membership organizations of minority groups. This is true even if the agency or foundation is headed or largely staffed by members of the minority. As with others, so with the blind. More and more of the governmental agencies and private foundations are becoming responsive to the views and needs of the blind and are learning new concepts and attitudes about blindness. The future looks bright. There is an overwhelming feeling of goodwill and a wish to help on the part of the general public. Most important of all, the blind are moving forward to speak for themselves and take a hand in the management of their own affairs through their organization, the National Federation of the Blind.

Programs And Services

By means of speeches, pamphlets, radio, and TV appearances, members of the NFB strive to educate the general public to the fact that the blind are normal individuals who can compete on terms of equality with others.

The Braille Monitor is a monthly publication of the NFB devoted to news and discussion of issues important to the blind. It is published in Braille, in print, and on record, and is available to the blind and the sighted alike upon request.

Detailed studies of state programs for the blind are carried out by the NFB when officially requested by state governors or legislatures.

Scholarships are awarded to blind students. Assistance is given to blind persons who are the victims of discrimination or whose rights have been denied. Such assistance takes the form of initiating court action, negotiating with public officials, conferring with private groups or individuals, and seeking publicity in the press and otherwise.

Future Reflections is the NFB magazine for parents of blind children. Through this magazine and other means, the blind of this generation reach out to offer help and encouragement (through parents) to the blind of the next generation.

New state and federal laws and regulations concerning the blind are researched. The blind are informed of services available to them and of their rights under the law. Consultation is provided to congressional committees and state legislatures, as well as to federal and state administrators. Local and state leaders of the blind from throughout the country are brought together for seminars to give them information to take back to their home communities and pass on to others. The Federation recently promoted and helped develop and evaluate a reading machine which translates the printed page into spoken words. Other new technology is also being evaluated and promoted. In short, the National Federation of the Blind is prepared to improve the lives of the blind.

Job Opportunities For The Blind

The NFB works to insure that training in the techniques necessary to function efficiently training is available in every state, but often it leads only to sitting at home, or making brooms in a sheltered workshop for less than $1.00 an hour.

Blind people today work as lawyers, psychologists, machinists, farmers, hairdressers; but the best estimates indicate that 70 percent of those who are able to work still do not have jobs or work only a few days a month in sheltered workshops. Many thoroughly capable blind persons have never had a job.

To respond to this critically high unemployment rate, the National Federation of the Blind, in cooperation with the United States Department of Labor, developed a program of Job Opportunities for the Blind. JOB helps qualified blind people who are looking for work find employers with job openings. JOB also helps employers who have affirmative action requirements for hiring the handicapped find truly qualified employees, not just token blind people to meet a mandated government order. JOB conducts educational seminars about blindness for employers, and career planning seminars for unemployed blind people.

Protection Of Rights

There are barriers to full participation in society by the blind. The National Federation of the Blind stands ready to help blind people overcome these barriers when collective action is necessary.

Many blind mothers and fathers are currently experiencing challenges from social service agencies who want to take their children. The recent increase in the number of such reported instances reflects not just an increase in government meddling or custodialism (although there is plenty of that), but heightened awareness and determination to take action on the part of the blind and their friends.

The National Federation of the Blind is responding to the challenge. A blind mother in Florida is once again busy raising her child without interference from a social service agency. The agency backed down when the National Federation of the Blind came to her defense. Several cases are currently underway in which blindness is a central question of a custody suit. Because the National Federation of the Blind was not contacted, it is already too late for some blind mothers and fathers. The organization is determined to establish sound case law on this issue.

The NFB Is Important To You

Blindness knows no discrimination. Any child can be born blind. Any individual can become blind in childhood or in later life. It is in the best interest of every individual to understand blindness and how to cope with its problems.

You Can Help

The most important thing you can do is help us spread the new concepts about blindness. When you see our literature in the mail or meet one of us on the street, remember that we are people, just like you--with all the range of talents and capacities, wits and wants that you possess. You can also help by making cash contributions to our organization or remembering the National Federation of the Blind in your will. The National Federation of the Blind is principally supported by public contributions. Donations are tax deductible.

Members-At-Large

Interested sighted people are encouraged to join the National Federation of the Blind. You can help us in our work by becoming a member-at-large and an Associate. Associates receive regular mailings providing updated information of programs and activities of the organization. Many sighted people have already become Associates in the following classifications:

- Associate--$10
- Contributing Associate--$25
- Supporting Associate--$50
- Sponsoring Associate--$100
- SustainingAssociate--$500
- Member of the President's Club--$1,000

To become a member-at-large send your name, address, and your dues and Associate contribution to: **The National Federation of the Blind, 1800 Johnson Street, Baltimore, MD 21230**

WHAT YOU ALWAYS WANTED TO KNOW BUT DIDN'T KNOW HOW TO ASK

(Resource List)

We have not tested all these products and are simply stating their availability.

Books

Diabetes Reach for Health and Freedom by Dorothea F. Sims, Mosly, 1984
This book covers all facets of diabetes for insulin dependent and non-insulin dependent diabetics. It can be obtained through the American Diabetes Association, 2 Park Ave., New York, NY 10016

The Diabetics Sports and Exercise Book; Dearman/Barbary, J.B. Lippencott, 1977

Fabulous Fiber Cookbook; Joan Gene, 101 publication, San Francisco: 834 Mission St., San Francisco, CA 94101

Tapes

Joslin Diabetes Tapes; Write to: Joslin Tapes, 820 Statler Office Building, Boston, MA 02116

Diabetes '86 - quarterly newsletter

Diabetes in the News on Tape (bi-monthly newsletter.
Both of these should be available through your State Library for the blind and physically handicapped. If your Library doesn't have these and if you are a member of the Diabetic Division of the National Federation of the Blind, you may obtain these at no charge through Mr. Howard Tegeland, S.D. Library for the Handicapped, 800 N. Illinois, Pierre, S.D. 57501

Diabetes As A Way of Life; T.S. Damoski, M.D.
Available from your state or regional Library for the Blind and Physically Handicapped.

Equipment

B-D Magni-Guide
Magnifies scale on syringe, snaps onto vial to allow curved magnifying surface to guide

needle into vial. Available from Becton Dickinson and Company, Rochelle Park, N.J. 07662 (Order H 8290-008233).

Insulgage Syringe Guide
Sturdy plastic gauge that slips onto the plunger of a syringe to position the plunger at a specific insulin dosage. Available from Meditec Inc., 9485 E. Orchard Dr., Englewood, CO 80110, Phone: (303) 771-4863.
Click/Count Syringe
Measures insulin by making audible clicks as insulin is drawn up. Ejects smoothly.

Self Blood Glucose Meter with Electronic Voice (Medicare and other private insurance carriers will usually cover the cost of this device.) For more information about both the syringe and the glucose meter contact: Orange Medical Instruments, 3183 Airway Ave., Suite F, Costa Mesa, CA 92626, Phone 714-641-5836 (Outside of California: 800-527-1151)

Resource Centers

The National Federation of the Blind has anything and everything pertaining to blindness. Materials are available in print, Braille, record disc, cassette, and book form. There is no charge for most NFB literature. For more information contact: The National Federation of the Blind, 1800 Johnson St., Baltimore, MD 21230; Phone: (301) 659-9314.

Diabetes In The News (DITN) is a bi-monthly newsletter, print copy cost $6.00/year. Discounts are available to long-term subscribers. Write to DITN, P.O. Box 3105, Elkhart, IN 46515 Phone: (312) 664-9782.

Materials and Aids for the Visually Impaired Diabetic - listing of literature in Braille and on tape. Write to: National Diabetes Information Clearing House, Box NDIC, Bethesda, MD 20205; Phone: (301) 468-2162.

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1985 FACT SHEET ON DIABETES

DIABETES: A Serious U.S. Health Problem--Today, more than 12 million people in the United States are afflicted with diabetes, one of the worst diseases of our time. In 1985 alone, the lives of 600,000 more Americans will be threatened as they become diagnosed with the disease.

Diabetes is a serious U.S. health problem that places a severe human and financial burden on people with the disease. According to the latest government statistics, diabetes is a tremendous $18 billion-a-year drain on the U.S. economy.

WHAT IS DIABETES?--Diabetes is a disease in which the body does not produce or properly use insulin, a hormone that is needed to convert sugar, starches and other food into the energy needed for daily life. It often leads to serious complications that involve nearly every tissue of the body. When high levels of sugar build up in the blood, heart disease, kidney disease, blindness, nerve damage and leg and foot amputations from gangrene occur.

Diabetes research has resulted in exciting new progress in improved treatment and care of people with diabetes. Self blood glucose monitoring, pancreas and islet cell transplants, anti-diabetes medications, laser therapy to prevent diabetes-caused blindness, and new insights into diabetic dietary needs, are some of the recent advances that are resulting in longer, healthier lives for many persons with diabetes.

There is no cure yet for diabetes. ADA scientific experts are confident that recent research discoveries will lead to a cure. They are even optimistic that a vaccine to prevent diabetes in children will be available by the year 2000 or sooner.

TWO MAJOR TYPES OF DIABETES--Type I, Insulin-Dependent Diabetes: An estimated 500,000 children and young adults have Type I, insulin-dependent diabetes. This severe form of the disease occurs most often during the flu season. The ADA has alerted health care professionals and the public about this high-risk period to ensure correct diagnosis and help prevent needless deaths. Immediate medical attention is required to avoid coma and death. People with diabetes must take insulin injections daily to stay alive.

INSULIN CONTROLS DIABETES. IT DOES NOT CURE THE DISEASE OR PREVENT ITS LIFE-THREATENING COMPLICATIONS.

Warning Signs of Type I diabetes include:
--frequent urination accompanied by unusual thirst
--extreme hunger
--rapid weight loss with easy tiring, weakness and fatique
--irritability, nausea and vomiting.
THESE SYMPTOMS OCCUR SUDDENLY. SEE A DOCTOR IMMEDIATELY.

Type II, Non-Insulin-Dependent Diabetes--The majority of people with diabetes have Type II diabetes, which usually develops in persons over 40. Obesity is a major contributing factor in the development of non-insulin-dependent diabetes. Proper diet and exercise are essential to controlling this major form of the disease, although oral medication or insulin may be required.

The onset of Type II diabetes is often gradual and undramatic. Many Americans first become aware they have the disease after they develop one of its life-threatening complications (i.e., heart disease, kidney disease, eye problems).

Warning Signs of Type II diabeates may include any of the previously mentioned signs or the following:
--over 40, overweight and have relatives with diabetes
--blurred vision or any change in sight
--tingling or numbness in legs, feet or fingers
--frequent skin infections or itchy skin
--slow healing of cuts and bruises
--drowsiness
ASK YOUR DOCTOR TO TEST YOU FOR DIABETES IF YOU HAVE ANY OF THE SYMPTOMS OF TYPE I OR TYPE II DIABETES.

THE DANGEROUS TOLL OF DIABETES:

1. One in every 20 Americans has diabetes.
2. Diabetes, with its complications, is the number three cause of death by disease in the U.S.
3. Diabetes is the number one cause of **new** blindness in adults aged 20-74.
4. More than two million Americans are hospitalized each year because of diabetes.
5. People with diabetes are twice as prone to heart disease and stroke.
6. Diabetic patients are 17 times more prone to kidney disease.
7. Diabetes causes 40,000 leg and foot amputations, which represents one-half of all amputations performed annually.
8. Black Americans have a 30-40% higher rate of diabetes, and black females have the highest death rate.
9. Hispanic Americans are three times more prone to diabetes than other groups in the U.S.

HOW THE AMERICAN DIABETES ASSOCIATION CAN HELP YOU: In your community, and in more than 700 others in all 50 states, the Association is the only full-service voluntary health organization in the diabetes community. It offers many patient education and family services, counseling and self-help programs, camps and youth activities. It the is leader in providing physicians, nurses, social workers, dietitians, pharmacists and other health care professionals with the latest information on the treatment and control of diabetes.

The Association is conducting a comprehensive Clinical Education program to provide all primary care physicians (who treat the majority of persons with diabetes) with the most up-to-date methods in the diagnosis and treatment of Type II diabetes. This nationwide program also will seek to find and provide treatment for the five million undiagnosed diabetic Americans.

The Association supports a multi-million-dollar annual research program. It is committed to raising $100 million before 1990 to be used exclusively to support top scientific efforts seeking the cause and cure of diabetes.

WHERE TO GO FOR HELP OR INFORMATION: If you have diabetes or think you do, or would like information for a loved one, contact the American Diabetes Association listed in the White Pages of your local telephone directory. Membership information may be obtained by contacting the American Diabetes Association, Two Park Avenue, New York, NY 10016, telephone: 1-800-227-6776.

FIGHT SOME OF THE WORST DISEASES OF OUR TIME—SUPPORT THE AMERICAN DIABETES ASSOCIATION.

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AMPUTATIONS AND PREVENTION

by Ken Carstens

I am a diabetic and have been one for almost forty years. I am blind and I am the president of the Iron Range Chapter of the National Federation of the Blind. Ten years ago my kidneys failed and I received a kidney transplant at the University of Minnesota Hospital; the kidney was donated by my sister. Less than one year later a sore on my toe that would not heal became infected and my left leg had to be amputated.

When returning to the University for the many clinic visits after a transplant you cannot help but notice the many amputees, most of them diabetics. As most of us know that have been diabetic for a number of years, we experience cold feet and sores that are slow to heal on our legs and feet. This is caused by poor circulation of the blood to the outer extremities of our bodies.

Last winter I bought a pair of shoes that was too tight and I got a blister on my toe that promptly became infected. The infection was controlled by antibiotics, but my doctor recommended a visit to the transplant doctors at the University. They have found that the blood can be rerouted down the veins instead. The many little doors in the veins are opened so the blood can flow opposite the normal way and arteries are cleaned when possible. The procedure is called Insitu Saphenous vein bypass graft.

I was admitted the afternoon of my first visit for an angiogram which showed severe blockage below the knee. I was told that this operation should help to keep my remaining leg years longer. I was operated on in March. I was in the hospital for eight days but was up and walking a few days after the operation. I was told later that one of my arteries was completely blocked and that I was very lucky to still have that leg. I enjoy walking and riding our tandem bike and this was probably the reason that I had not lost that leg also. I was also told that if I could have had this operation years before, the chances are that I still could have my other leg.

I cannot stress too much the use of proper foot care and lots of exercise for diabetics.

Anyone interested in this operation should contact his/her doctor or Department of Surgery Associates, Phillips Wangenstein Bldg. Room 11-118, 516 Delaware St. S.E., Box 195, Minneapolis, Minn. 55455. Phone: (612) 376-5194.

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INTRODUCING DR. JAMES

Dr. Ronald James is an insulin-dependent type I diabetic. He has had diabetes for 35 years. Dr. James has graciously consented to assist us by being the doctor who will answer questions from diabetics concerning diabetes.

Dr. James is 47 years old. He graduated from the University of Missouri-Columbia, in 1964 with an M.S. in Biochemistry and in 1965 with an M.D. From 1962-1963 he held a Post-Sophomore fellowship in biochemistry, and has been honored by Sigma Xi, Phi Kappa Phi, and the Tau Beta Pi honor Engineering Association. From 1971-1976 he worked in the Department of Medicine, University of Missouri School of Medicine and Veterans Administration hospital; and is now working with the Midwest Diabetes Treatment and Education center, and is the medical director of the Central Missouri Diabetic Childrens Camp, Inc.

Question 1: What is the best treatment for a minor cut or any break in the skin? I have been a diabetic for 23 years and have had a kidney transplant, so I am taking immunosuppresants.

Answer 1: In my opinion the best treatment for any minor cut or abrasion of the skin is to clean it well. Use either soap and water or some mild antiseptic agent. There are differences of opinion among physicians as to whether one should use a local antibiotic preparation. I seldom do. Certainly the immunosuppresants make it more likely that such a leison will become infected. However, I would not use antibiotics taken internally unless there is some evidence of infection. It would be well to cover the leison with a bandage such as gauze to keep from contaminating it.

Question 2: What are the latest developments in cures for diabetes?

Answer 2: The latest development toward a cure for diabetes is work with the transplantation of islet tissue that is going on many places around the world. At the present time no one has developed a successful method for transplanting the islets that does not require immunosuppresants. Because of the side effects of these agents, it is unlikely there will be a practical cure for most diabetics until a method other than use of these drugs is found to prevent rejection. Exceptions are those who are already taking immunosupresants to prevent rejection of other organs such as a kidney. The side effects of the immunosuppresants are more of a concern than diabetes itself. Methods of doing islet transplants without the use of the current types of drugs is under investigation.

Question 3: Is there an advantage for all diabetics in using human insulin?

Answer 3: At the present time there does not appear to be any significant advantage for most diabetics who are already taking beef, pork or beef/pork mixtures of insulin to switch to Human insulin. A possible advantage to starting all new diabetics on human insulin is that they are less likely to develop antibodies to human insulin and thus have any possible problems such as allergy associated with these antibodies. The real advantage of switching all diabetics to Human insulin is that it will help speed up the transition from animal source insulins and eliminate the availability of beef and pork insulins and thus the problems a few diabetics have with them.

Question 4: I am an insulin dependent diabetic on a 400 calorie per meal diet. Could I occasionally eat a 330 calorie piece of cake instead of other foods?

Answer 4: Although some physicians would say it is all right to eat the 330 calorie piece of cake instead of your usual 400 calorie meal, I would say no. First the 330 calorie piece of cake will probably not be equal in available carbohydrate to that of the 400 calorie meal. Therefore, you would not be getting the same amount of glucose as that produced by thee 400 calorie meal. This can make a difference in your blood sugar. More importantly, the cake contains a relatively large amount of sugar which is readily available carbohydrate but does not contain much protein. Therefore, it is likely to cause the blood glucose to rise higher than it usually does shortly after the meal and give less protection against hypoglycemia later on.

Question 5: Sometimes when I feel like I'm having early insulin reaction symptoms I actually have high blood sugar--why? If I am away from home and can't do a blood sugar test what should I do?

Answer 5: Early during an insulin reaction one may not be able to determine whether his blood glucose is high or low because symptoms of an early insulin reaction as well as those of high blood glucose are not always very specific. If one is unable to do a blood glucose test under such circumstances he must use sound judgement in considering all of the facts and determining what should be done. How one usually responds to high or low blood glucoses will have an influence. If high sugars cause significant problems such as nausea, vomiting, or diabetic ketoacidosis, then this must be taken seriously and evaluated and treated immediately. On the other hand, if one does not readily get into significant difficulty with temporary episodes of hyperglycemia, it might be best to wait until the symptoms progress to the point where one can be sure whether the sugars are high or low. On the other hand, if one has difficulty recognizing insulin reactions, I would suggest that you go ahead and treat it as if it were an insulin reaction even in the face of what could possibly already be high blood sugar. Again one must individualize the response to the particular situation.

Question 6: Are there any diuretics that do not effect blood sugar levels?....if Yes, which ones?

Answer 6: It is well known that many diuretics such as the thiazides, furosemide, and ethacrynic acid tend to elevate blood glucose levels. One mechanism for this effect is that they produce urinary potassium loss and hypokalemia which in turn is known to inhibit insulin secretion and thus contribute to hyperglycemia. The thiazides are known to also have other effects in terms of elevating the blood glucose levels. Some diuretics such as Triamterene (Dyrenium) and Spironolactone (Aldactone) do not produce hypokalemia and hperglycemia. It needs to be kept in mind that anyone with a condition requiring a diuretic may need to be treated with potassium supplements unless the diuretic is combined with a second, potassium sparing diuretic. It is my feeling that one treats the condition requiring the diuretic and then manages the hyperglycemia as indicated, even if insulin therapy is necessary.

Question 7: What are the pros and cons of an insulin pump?

Answer 7: In favor of the insulin pump is the higher level of diabetic control that can often be achieved. The pump can more nearly mimic physiological insulin production than injections because it provides a continuous basal infusion of insulin as well as boluses on command. This allows one to better match the insulin to food intake and other factors affecting the blood glucose. This in turn may help delay or prevent the chronic complications of diabetes. **Problems** with the insulin pump are many. Pumps cost hundreds of dollars, often more than $2,000 initially. Supplies for one year often cost several hundred dollars. Problems in the use of the pump include pump failure which may be due to mechanical failure, to battery failure, or to operator error. There is the increased risk of night time hypoglycemia because of the continuous infusion of insulin. There is also an increased incidence of diabetic ketoacidosis. This is probably due to the fact that pump patients usually monitor blood glucoses but may not routinely monitor ketone levels. Therefore poor control can "slip up" on one and he may develop ketoacidosis without being aware if it. Some diabetics object to the pump because others may see them wearing it or because it "gets in the way" or may be damaged by contact with other things in the environment. The pump takes time and requires a dedicated effort.

Question 8: How important is it to mix two kinds of insulin, such as regular and NPH; and should I take more than one shot per day?

Answer 8: The important concept to remember is that the diabetic should receive insulin around the clock to match his needs and in particular to match the times at which he is consuming food. In my opinion this always requires a minimum of two injections daily. This may be done by taking mixtures of regular and NPH insulin twice daily before breakfast and before the evening meal. Another way is to take regular insulin before each meal and an injection of some type of insulin during the night. This last dose might be regular insulin at approximately midnight or NPH insulin at about bedtime. The important thing to remember is that one needs to have his regimen designed in such a way that it provides insulin around the clock.

Please note: If you have any questions for Dr. James please send them to the editor. The only questions Dr. James will be able to answer are the ones used in his column.

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POSSIBLE CURE FOR DIABETES

"Cyclosporin and Occular Diabetes" (Reproduced with permission from Topics in Ocular Pharmacology and Toxicology, Marvin B. Smith, Ph.D., R.Ph., Editor, copyright 1985 by PSG Publishing Company, Inc., Littleton, Massachusetts.)

Diabetes mellitus or "sugar diabetes" afflicts approximately 300,000 each year and ranks third behind heart disease and cancer as a killer. It is a leading cause of blindness. Although major discoveries and treatments such as insulin in 1922, the oral hypoglycemic tolbutamide in 1956, the insulin pump in 1978, human insulin via genetic engineering in 1980, and others have occurred, a cure for diabetes and especially its ocular sequela has not been forthcoming. However, recent research and the drug cyclosporin may lead to a cure for diabetes.[1,2]

Current research seems to promise that diabetes mellitus may eventually be cured by surgical transplantation of healthy, insulin-producing tissue from a donor to a recipient utilizing immunosuppressive agents such as cyclosporin. Some research also seems to point to the successful use of cyclosporin alone in producing remissions in newly diagnosed diabetic patients.

Cyclosporin

Cyclosporin is a drug that has been credited with revolutionizing transplant procedures.[3] In this context, segmental pancreatic transplantation may provide a brighter outlook for the multitude of patients with diabetes.[4]

Cyclosporin therapy produced a complete remission in 33% of 12 newly-diagnosed insulin-dependent diabetics. These patients were able to stop taking insulin, and four other patients were able to have their insulin requirements halved. There were no reported side effects from cyclosporin in the doses used in this study. However, higher cyclosporin doses and simultaneous administration of steroids produced lymphomas in 0.4% of transplant patients.[3,5]

Transplant cures

In 1966, the first successful pancreas transplant was performed by researchers at the University of Minnesota. Although the body rejected this transplant, this procedure focused on a possible surgical cure for diabetes, providing the transplanted pancreas would not be rejected. In 1970, researchers at Washington University in St. Louis successfully transplanted insulin-producing beta cells in rats. Therefore, the entire pancreas may not be needed. In 1984, at the University of Miami, islet cells were transplanted into diabetic dogs to "cure" the disease. In the same year, newly diagnosed diabetics at the University of Western Ontario were successfully managed with cyclosporin.[2,5]

Cyclosporin Controversy

If diabetes mellitus is a disease caused by the immune system of the body, then an immunosuppressive agent could "cure" the disease. However, if diabetes is caused by other factors, then immunosuppressive agents such as cyclosporin could create problems.

The relationship between cyclosporin, steroids and the potential for lymphomas, produces concerns for consideration of a benefit-to-risk ratio judgement.

Other ocular implications of cyclosporin

Cyclosporin, when given to two patients with thyroid exophthalmic goiter, produced a rapid, objective improvement. This improvement included restored ocular-muscle function and visual acuity, improved exophthalmia, and reduced orbital muscle swelling.[6] Cyclosporin also seems effective in treating selected patients with severe bilateral uveitis of noninfectious etiology who are not responsive to steroids or cytotoxic management. Seven of eight patients responded with improved visual acuity and decreased uveitis.[7]

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Addendum: After about 5 years of testing, Cyclosporin was approved by the Food and Drug Administration in November, 1983. It has most widely been used to suppress the immune system in kidney transplantation. It has proven to have two major benefits; much less serious post-operative infection and must less kidney rejection. Kidney graft survival has proven to be over 20% higher than before cyclosporin. Immuran is still the immunosuppressive drug most widely used. These immunosuppressants destroy certain white blood cells which attack the new, or invading, kidney.

MANAGEMENT OF THE DIABETEIC PATIENT WITH KIDNEY DISEASE AND BLINDNESS

Dr. John Najarian, Chief of Surgery at the University of Minnesota Hospital spoke to the NFB convention on Thursday, July 8, 1982, and was introduced by Karen Mayry, President of the NFB of South Dakota. She said: "Eileen O'Brien and I are both successful kidney transplant patients who have come to know Dr. Najarian very well. About a year or so ago we talked with each other about this. We wanted diabetics who did not already know about the good program at the University of Minnesota to learn about it. We wanted to offer a support group to diabetics who are having renal failure. During the past year, we have set up what we call the Network. Many diabetics have contacted us. We have talked with them by phone and correspnded with them. This morning the diabetics here at convention met, and we'd be happy to meet with others following the morning session.

"Dr. Najarian is one of the individuals who helped develop the kidney transplant. I have had my transplant for 5-1/2 years and am doing extremely well. Dr. Najarian asked me: Aren't you tired after this convention? Of course, we're all tired, yes. But we'll worry about that when we get home. We now have the Network established, and we're hoping to help all diabetics who have renal failure. As I present Dr. Najarian, I want you to know that he is a member of this organization and an Associate."

Dr. Najarian spoke as follows: "Karen is an inspiration to all of us at the University of Minnesota as are some 475 other diabetic patients we have transplanted over the past 13 years.

"I would like to talk with you a little about diabetes, about kidney transplantation, and a little about pancreas transplantation. Diabetes plays an important part in blindness. It may be one of the major contributors to blindness in the United States today. The things that we know are that it's the second most common cause of blindness; and its the leading cause of new cases of blindness in adults. Diabetics in general are 25 times more prone to become blind, 17 times more prone to have kidney disease, 5 times more prone than non-diabetics to get gangrene of their extremities, and twice as prone to have heart disease.

"When we first started transplanting kidneys in 1962, we began transplanting non-diabetics, people who had kidney failure for other reasons. In 1967 I wanted to know why diabetics were not being transplanted. There were two major reasons. One, the people who do dialysis (the artificial kidney) were not interested in the diabetic because the results of treating diabetics were so poor. Because of this, the people in transplantation were also fearful of transplanting diabetics. They have to be placed on cortisone (prednisone), and this would cause their blood sugar to get worse. As a result, it may make it more difficult to transplant such patients. We did the first transplant in 1966 on a patient with diabetes, who at that time was partially blind. He had kidney failure. We went ahead with a kidney and a pancres transplant in combination. At that time we felt you had to do both: replace the kidney because the kidney had failed because of the diabetes and then try to correct the diabetes by giving a new pancreas. This was an unfortunate philosophy at the time, because all of our first ten patients in whom we placed both a kidney and pancreas at the same time eventually lost both of these organs and eventually lost their lives, although for a short period of time both the kidneys and the pancreas did work. We stopped doing that in 1968. At that time we said: If 50% of all diabetics living today are going to die of renal failure, let's just put in a kidney, and see if we can manage them in that way. We started doing kidney transplants in 1968. We have done them now for the past 14 years on diabetics. Although we are the largest kidney transplant program in the world, having done almost 1800 kidney transplants altogether, we are the leading transplant proponents of transplanting diabetics, having done 475, which represents perhaps one third of the diabetics ever transplanted. We think it's important. By continually reporting our results to medical meetings, we were able to shame our colleagues (if you will) into transplanting diabetics. I am proud to say now that most transplant centers in the United States will transplant diabetic patients today.

"If you do nothing but transplant the kidney in the diabetic patient who is dying because his kidneys have failed, that will save his life, but what about his eyesight? The most amazing thing has occurred. In the past 14 years in reviewing the eyesight of all our diabetic patients, 33% or one-third are blind when they come to us (totally blind), and the others have some degree of retinal problems and blindness. At the present time, of those with any sight whatsoever, we have been able to improve the sight in 17%. We have been able to stabilize the eyesight at whatever level they were when we saw them in 62%. Only 21% over the past 14 years have had further deterioration in their eyesight. The reason for this is amazing. Why can just a kidney alone preserve failing eyesight in the diabetic? It has to do with why eyesight is lost if you're diabetic. During the last phases of kidney disease, you become hypertensive and get high blood pressure and you have bleeding problems. With these two things, you eventually have a very fast progression of loss of eyesight. If you can stop the uremia by putting in a new kidney and normalizing the diabetic, then you can stabilize the eyesight. This has gone on for 14 years in almost two-thirds of the patients that we've transplanted. More amazing, how do you improve eyesight with simply a kidney transplant? We look at the patients that we've done. We have some excellent ophthalmologists that work with us. We have seen a decrease in the macular edema. This is the fluid around the area in which the eye is able to see. We have absorption of vitreous hemorrhage which is the major cause of the immediate blindness that the diabetic experiences. And we have been able to do vitrectomies, remove the vitreous humor within the eye where the hemorrhage was present to prevent further progression and improve eyesight. In some instances we did an operation on a cataract if the patient had a cataract. Our friends in ophthalmology are of great help as all of you know. They're the ones who have blasted the way along with us in not only looking at what's going on in the diabetic but all others with failing eyesight.

"I'll just mention a word or two about the kind of progress that's being made there. The laser has been one of the most remarkable things that the ophthalmologist can use for stopping the progression of sight loss, particularly in the diabetic. Some circumstances we know. When you have what we call proliferative disease (lots of extra blood vessels get in the back of the eye of the diabetic) we can destroy them with a laser beam. By destroying those, we can (in fact) then improve the eyesight or stabilize it so it doesn't go on to total blindness. In addition, with the laser we can take care of what we call macular edema. That's the area of your eye that sees. It gets too much water in it. The reason the water is there is because the capillaries are leaking in that area. With the use of the laser we can block those capillaries and slow down that problem. In addition, a remarkable thing is a vitrectomy, the ability to remove the vitreous humor in the eye. We do this only when there is hemorrhage in the vitreous which does not absorb. Then it can be removed. In addition we have a thing called traction retinal detachment, when the retina is pulled away from the back of the globe of the eye. This can be prevented by use of vitrectomy. With all these things in mind and in our hands and with the increased technology that's going on now, the improved techniques in material we can use, vitrectomy and laser therapy have done a remarkable job in at least holding off progression of eyesight loss, and particularly in diabetic patients.

"I cannot overstress the importance of transplantation in those diabetics who need it to stop further progression of loss of eyesight. Remember, if you have any eyesight at all and you're diabetic and you get transplanted--two-thirds will stabilize that eyesight and approximately 20% more will actually have improvement. Therefore, I think this is something very seriously to consider.

"Let's think for a moment about diabetes a little bit differently. There's only one real way to cure diabetes. That's with the use of a pancreas transplant. The trouble with the diabetic is that his pancreas doesn't work. The islets of Langerhans (little areas within the pancreas that make insulin) do not work. They're destroyed. We don't know how they're destroyed. We think it's probably viral in nature, but they're destroyed. If we can give a new pancreas, then in fact we can cure the diabetic patient. We began, as I stated before, back in '67 with trying to give a pancreas and a kidney to the diabetic patient. It turned out to be too much of an operation for them.

So we stopped and did kidney transplants alone. But we didn't quit. We went back to the laboratory and we said: Maybe we can just take out the cells within the pancreas that make insulin, the islets themselves, and transplant those. Maybe that's enough. We tried that on 20 patients. We could lower the amount of insulin they were taking, but we could never cure a single patient with that technique. In 1978, then, we went back to looking at our old technique, but one that was perhaps a lesser technique of pancreas transplantation, that is to give just half the pancreas in transplantation, something we call segmental pancreas transplant. It provides two new opportunities. One, and foremost, you can use a living related donor. In other words, you could use a mother or father or brother or sister where you take half the pancreas and leave half with the original donor. That was one advantage. The other is that it's a much lesser operation than using the whole pancreas as we had before. It is less stressful on the diabetic, and perhaps there is more chance of success. I'm happy to say that in the last four years since we started this, we have done 50 pancreas transplants in diabetic patients, and a total of 46 patients. Four of those patients received a second transplant because of rejection of the first. In those patients in every instance we've had function. We've been able to take the patients off insulin at least temporarily. Eventually, some of these pancreases have failed for a variety of reasons. They have failed because of rejection of the tissue itself which we couldn't stop with our current drugs or they failed because of technical reasons. There are things we have to learn about making this a better operation. Today we have a better operation. Today we can transplant a pancreas and we currently have 16 patients out of that 46 who are completely off of insulin altogether. For those of you who are diabetic, you know what that means. Sticking yourself once, twice, three times a day; being on an insulin pump; watching your diet; and all the rest that goes with it. To be able to throw that away in one fell swoop is amazing. We're getting there now. We're just beginning to get there now. Those of you who are not diabetics, it's easy to empathize with the diabetic and to realize what kind of a problem that it. If you're not diabetic, think about it for a moment. You're now totally blind and you have to give yourself insulin. Think about what you have to do.

"What's going to happen in this area? Currently, our longest patient is four years. One of the first patients we did with the pancreas transplant has not taken a drop of insulin in four years. She appeared in a journal called Diabetic Forecast about two years after her operation. When we first did her, she was legally blind. This meant that she had 20/200 vision in her best eye. Currently, she has 20/30 vision in her eyes. Interestingly enough, she is working in Pittsburgh for a transplant unit. She is doing social work for them and doing it very well. This is the kind of thing that can be achieved. Not only do the eyes get better, but the kidneys which have become worse with the diabetes also get better. The kidney function improves once the pancreas is corrected. These are good things that have come along.

"It would be remiss for me not to include one final thing that has come along with the diabetics. That is that, not only are pancreas transplants coming, but we are also developing artificial pancreases as well. These are instruments in which insulin can be delivered to the body without the injection process. They can be used as an insulin pump on the outside of the body with a needle placed in the abdomen or they can be implanted as pumps inside the body and injected and filled with insulin every two weeks or more or less, depending on how much insulin they're taking, and they continually work day and night. They're not ideal, but they're a lot better than sticking yourself with a needle. With better control (all diabetics can tell you) your chances of having complications will decrease remarkably. Control is the answer, and if insulin pumps help provide that, then that's an extremely important advance as well. So there's hope. There is the possibility of pancreas transplants for those who need them, although that's generally not the first thing that's needed. Usually the first thing that's needed is a problem with the kidneys. They should either be on dialysis or they should be transplanted, and preferably transplanted. If the pancreas continues to come along as it is, then I think that's going to offer real hope. And the insulin pumps also offer hope.

"This is the message that I have for you today. I think it's an upbeat message. It's the first time we've had something really concrete to look at in an important or leading cause of blindness today, mainly diabetes mellitus."

There were a number of questions from the audience for Dr. Najarian. Eileen O'Brien asked him to comment on the use of dialysis versus the kidney transplant. This is what he said: "The question really is when a diabetic is in kidney failure should he go on dialysis, the artificial kidney treatment, or transplantation? Obviously, I am a transplant physician, and I would push that. There is no data at the present time to show that dialysis is any more than a holding pattern, and not a very good one for most diabetics. Diabetics are hard to dialyze, and the results at the end of a year or two will be worse than they will with transplantation by ten to fifteen percent. More importantly, dialysis itself has an adverse effect on the eyes if there's still sight present. The patients on hemodialysis (that's where the blood vessels are used) have to be placed on blood thinners. Often this causes a problem with further hemorrhages in the eyes. In essence, if you have a choice, the choice should always be for transplantation. Even the best and most honest dialyzer will agree to that. If you don't have a choice then dialysis is second best."

Evelyn Saile asked is there a limit to how old a person can be and still be eligible for a kidney transplant? Dr. Najarian answered: "Most of the transplants we do are in people under the age of 55. We've recently raised it to 60. You begin to get into too many problems with older patients when they're placed on the kind of drugs you have to place them on to keep a kidney or a pancreas in place. At the present time we've extended our horizons up to 60. They used to be 40. We're getting up there, but we're not yet talking about really the very elderly patient."

Connie Comorato asked about funding to pay for kidney transplants. Dr. Najarian answered: "I know of very few of our patients who have ever had to pay for the procedure. You can ask Karen and Eileen. At the present time the cost of the operation for a kidney transplant is funded by the Social Security Administration. That funding is up to 90% of total. Anything about that is usually covered by third party payments. I am really not aware of anybody that's had to pay for anything of any significance on a transplant."

Rick Plumstead asked about precautions to be taken in families where there is diabetes and about the expectations for inheritance of diabetes. Dr. Najarian answered: "It is hereditary, but the degree of inheritance is so poor that you can go for three or four generations and never see another diabetic. For the type of diabetes we're talking about, which is the juvenile onset diabetes, diabetes that occurs before the age of 40 or 45 years of age, I'm not talking about adult diabetes that occurs after the age of 45 which is a very mild form. It can often be treated by diet or taking pills. I am talking about juvenile onset diabetes. This is the bad one. How often should your children be tested? Not more often than once a year. The only thing that needs to be tested really is the sugar in their urine. If you get concerned, you can always get their blood sugars done. The diabetes that has onset after 45 is definitely inherited. The juvenile onset is what we call low penetrance. It's so spotty you really don't know. If you have diabetes and your wife or spouse does not, and you had 5 or 6 children, all of them could be free of diabetes. After 50, if there is anybody that has adult diabetes, you are very prone to getting it, that's if there are members of your family who have it."

Frank Snee asked what to do when there is numbness in the hand because of a fistula for dialysis in the arm. Dr. Najarian answered: "If your hand is numb and you are having difficulty with it, then they may consider closing that fistula and putting one in your other side. What happens with the diabetic is that the circulation is so poor that when we try to create a fistula (a communication between the artery and the vein) in order to do dialysis, we do rob the blood from the distal part which would be the hand. That's the reason why your hand is numb. If this becomes a very severe problem for you the fistula should be closed and another one created either in the other arm, or higher up in your arm."

Ruth Whelan asked how long a person could have diabetes and have a pancreas transplant attempted. Dr. Najarian answered: "I want to really stress this. When we're talking about a transplant today, we're not talking about all juvenile onset diabetics. The only ones that we're transplanting currently (and we've done 50 in four years, not a huge number although half of those who have been done in the world). At the present time the ones we're doing are those patients who previously had a kidney transplant and are already on immunosuppressive drugs. In isolated instances where we have patients who have rapidly progressive blindness or rapidly progressive disease secondary to their diabetes and do have a sibling (a brother or a sister) who is well matched to them so the risk of the transplant would be minimum, then we're doing transplantation. This is not open to all patients at this time. It's very experimental. We're just beginning to feel our way."

Louis Anderson asked how long after the onset of diabetes should one expect to have kidney problems. Dr. Najarian answered: "In general we found it takes about 20 to 25 years before the diabetes affects the kidneys."

David Walker asked for further comments on the insulin pump and on follow-up with the surgeon who did the kidney transplant or a nephrologist. Dr. Najarian answered: "I didn't mean that the insulin pump should be for everybody. It is one of the new things on the horizon. I'm just telling you the new things coming along. Selected people who are using pumps are doing very well. It is excellent for those who can use it and do use it properly. As far as follow-up with patients is concerned, all of our patients are followed by both the surgeon who did the kidney transplant and the nephrologist."

Although others in the audience would have liked to ask questions, President Jernigan was forced to terminate discussion and move on to other items on the convention agenda.

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EDITOR'S COMMENT

Several of our members have had kidney transplants and know without a doubt that the National Kidney Foundation slogan which says that the kidney is "the gift of life" is absolutely true. Any diabetic undergoing kidney dialysis treatments should give strong consideration to having a kidney transplant.

The reasons that several of our division members have chosen the University of Minnesota Hospital in Minneapolis, MN for their kidney transplants are simple:

1) The success rate for kidney transplantation at the University of Minnesota Hospital is among the highest, if not the highest, in the world.
2) They have worked with far more diabetic patients than any other transplant center.
3) It provides patients with a very detailed thorough transplant handbook covering all facets of kidney transplantation.
4) If desired, they provide cassette tapes of this same transplant book and other tapes pertaining to kidney transplantation and sugar diabetes.
5) If you live outside the Minneapolis area, there is a toll-free telephone number provided so the patient always has access to information and involvement in his transplant program.
6) If blind or visually impaired, the nurses will, if needed, show you how to draw insulin without assistance plus give you pertinent information in Braille.

If you desire additional information about the kidney transplant program at the University of Minnesota Hospital, you may use the following toll-free telephone number: 1-800-328-5465.

Our next newsletter edition will have facts and figures regarding kidney dialysis and transplantation. There will also be a story from someone who has donated a kidney to a loved one.

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MY "TRANSFORMATION"

by Betty Walker

I was born in 1953 in Dover Plains, New York. I became diabetic at the age of five. My childhood was more or less "normal". I graduated from high school in 1971 and earned an A.A.S. degree in Nursery Education in 1973 from Dutchess Community College in Poughkeepsie, New York. My problems began at this time.

Before the end of 1974, I was totally blind; the causes being Diabetic Retinopathy and Glaucoma. In January of 1978 I was confronted with renal failure. After coping with losing my sight, which I took day by day thanking God for each day, I felt this was just another of life's hurdles that I had to jump over. If I could not jump, I would climb; no matter how slowly I had to climb.

Most of the time while on Dialysis I was very ill. I could not eat because I was so nauseated. My social life was non-existent. I no longer enjoyed any hobbies. I was so tired that most of the time between Dialysis I spent in bed. Life went on like this for about six and one-half months. When I decided to have a transplant, I figured there was nothing to lose. Dialysis was always there to fall back on.

So, on July 13, 1978, I was "born again". My mother, Fran Bator, gave me life when I was born and gave it to me again when she became my donor. The transplant was done at Yale-New Haven Hospital. It should be called a "transformation" because that is what it was for me.

I could hardly believe it, but the day after the transplant I wanted to eat. I was told that I had to wait another day. When the next day came, given jello and gingerale, I told a doctor that I wanted "real" food. I ate like a horse the next day devouring all the food on my tray. I also felt like running or doing something to release my energy. My hematocrit rose from 12 to 40. All of my blood chemistries were normal. The only problem was with my blood-sugar which had risen because of the steroid drug. This was taken care of by more insulin.

For me the most frustrating thing was that I could not take a shower or bath until the stitches were removed. Wouldn't you know it, they left them in for sixteen days. As soon as the doctor removed the stitches and was out of the door, I was in the shower.

Since I have been blind I have a philosophy: I do not say something can't be done unless I try to do it first and know I can't do it. So far the only thing that I have found I can't do is drive a car.

I lead a fairly active life since my transplant. My favorite leisure activity is horseback riding. Yes, it can be done by a totally blind person. I also enjoy swimming, hiking, sailing, ice-skating, arts and crafts, cooking, baking and writing poetry. Included at the end is one of my poems, "Natural High", expressing my outlook on life.

In closing I would just like to say, "Never Give Up and Don't Let Anything Get You Down".

If anyone would like to write or call me, my address and phone number are: Betty Walker, 1826 Mississippi, Jefferson City, MO 65101. (314) 634-7969.

Natural High

Whenever I am feeling high,
I find it very hard to lie.
My face will have a big bright smile,
And when I talk; I talk a while.
My high is not from any drug;
I may be "up" just from a hug.
Its cause is just a love of life;
That I hold onto with great strife.

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RECIPE CORNER

We want to thank Owen T. Foltz, III, R.D., who works at the new Cosmopolitan Diabetes Center at the University of Missouri Hospital and Clinics in Columbia. He has provided calories and diabetic exhanges for our recipes. We also need you to send the editor any great recipes you have.

APPLESAUCE COOKIES (Diatetic)

by Gail Bryant, Columbia, MO

1-1/4 cups flour
1/4 tsp. salt
1/2 tsp. nutmeg
1 tsp. cinnamon
1/2 tsp. cloves

(recipe continued on next page)

APPLESAUCE COOKIES (continued)
1 tsp. soda
1 stick margerine
1/2 Tbsp. Sweet-10 (or 1 Tbsp Sucaryl)
1 egg or 2 egg whites (you may use 2 eggs and bake as bar cookies)
1 cup unsweetened applesauce
1/3 cup raisins
3/4 cup oatmeal

Mix dry ingredients. Add liquid. Bake at 375 degrees for 20 minutes (when making as bar cookie).
Yield: 3 dozen cookies
Calories: 145 per three cookies
Diabetic Exch.: 1 bread, 1-1/2 fat per 3 cookies

POTATO PANCAKES

1/2 raw onion, grated
2 large potatoes, grated (need not be peeled, but well scrubbed)
4 Tbsp. whole wheat flour
2 Tbsp. water
2 Tbps parsley, chopped

Mix all ingredients in a bowl. Lightly oil a griddle and heat to 325 degrees or medium heat. Ladle potato mixture onto griddle. flattening slightly. Cook about 8-10 minutes on first side. turn and cook an additional 5-8 minutes.
Helpful hints: Serve with unsweetened applesauce, diet or plain ketchup. If you have a non-stick griddle or frying pan, you will not need to oil it before using.
Yield: Serves 6
Calories: 90 per serving
Diabetic Exchange: 1 bread; 1/2 fat per serving

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GET-WELL COMMITTEE

We are a support group and as such we give support in many different ways. There are many complications of diabetes and if a person is hospitalized due to a heart attack, stroke, kidney transplant, amputation and so forth, he needs all the support we can muster.

It is extremely nice and means a lot if a person receives a get-well card while in the hospital. Sometimes the appropriate greeting might be a phone call or perhaps a welcome home card. In what way can we better serve as a support network than to reach out and give support?

We currently have people sending appropriate greetings to persons having a kidney transplant. We would like to expand our scope and send greetings to people undergoing other major problems. Ideally, we want people who have been in the same situation to send greetings. It would not be necessary that you had undergone the same problem in order to send greetings. The expressions of feeling and love can be transmitted by anyone.

Please contact the editor if you would like to be on our committee that would send appropriate greetings to someone in the hospital. It is very gratifying to offer support and love and give a crutch to lean on in a time of need.

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EILEEN O'BRIEN'S MOTHER DIES

Eileen O'Brien is First Vice-President of the Diabetic Division of the National Federation of the Blind and is an active federationist. For some time her mother has been incapacitated and on October 13th passed away. Eileen says that all memorial gifts will go to the Diabetic Division of the National Federation of the Blind. Any donations in memory of Mrs. O'Brien should be made payable to The National Federation of the Blind and sent to Eileen O'Brien, 791 Cambridge, Elmhurst, Illinois 60126. Eileen wants federationists to know that she is ready to get back to work and contribute to the Diabetic Division of NFB.

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It has taken much help to make this newsletter a success. We of the Diabetic Division of the NFB give our sincerest thanks to:
The National Junior Honor Society of West Junior High School, Columbia, Missouri for help with preparations for this mailing.

Gary Wunder, Senior Analyst Programmer, University of Missouri Hospital & Clinics Department of Pathology; and President of NFB of Missouri for preparing our mailing list in zip code order.

The National Federation of the Blind of Missouri for usage of their bulk mailing permit.

Daniel Boyd, Director of the South Dakota State Library for the Handicapped, for duplicating and distributing tapes at no cost to our division.

Dave Spotts, lay-minister and student at the University of Missouri, Columbia, for reading this newsletter onto tape.

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TIDBITS AND HUMOR

A supermarket customer commented to the cashier, "I can't believe it costs so much for such a small sack!" The cashier said, "Do you want a bigger sack?"

DIABETIC SUPPORT GROUPS

If you know of any diabetic support groups in your area, please contact Karen Mayry, President, The Diabetic Division. We need to know who the group is and who its leader is, with the correct address and phone number, if possible. We would like to have an interchange of ideas and experiences between the many diabetic support groups. We feel that by working together much more support can be provided to all diabetics.

Question: What do you give a pig with a sore throat?

Note: We do not have the man-power to research and be able to answer many medical questions. However, if you have a question specifically pertaining to diabetes to ask our friend, Dr. James, please write to the editor. Of course you should always be in contact with your physician, attend ADA meetings, go to the library, or attend classes that many hospitals have pertaining to sugar diabetes.

Answer: Oinkment.

Question: Did you hear who the clone of the founder of Baskin-Robbins is?

(Contrary to popular opinion, he is not the editor of this newsletter.) While the editor likes ice cream, he would rather have your stories about diabetes. Please submit any article you would like to see us print, or any ideas for what you would like to see in The Diabetic Support Network to Ed Bryant, Editor, The Diabetic Support Network. He looks forward to your letter.

Answer: The Ice Cream Clone.

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1986 BRAILLE CALENDARS

To receive your complimentary 1986 Braille Calendar, 5 1/2 x 6 1/2", please write to the American Brotherhood for the Blind, 1840 Oxnard St., Tarzana, CA 91356.

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From National Kidney Foundation: "Control of diabetes and high blood pressure puts dialysis machines in museums, not hospitals".

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Kidney Dialysis Needs

Dialysis needs for this year's National Convention are being arranged. We have several faithful Federationists who are always in attendance at our convention and need assistance in handling their dialysis needs. If you would like to attend this year's National Convention and will need to undergo dialysis treatments, please contact your Editor, Ed Bryant.

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1986 Diabetic Division Table

At this year's NFB National Convention in Kansas City, Missouri, our division will have a display table in the Exhibit hall. We are in need of suggestions for display items and most importantly help to work the table. If you will be available to help man our Division Table, please let us know.

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To purchase a cassette tape of The Diabetic Support Network fill out the following form.:

Check one:

/ / For the Diabetic Division of NFB Membership. I have enclosed 1.00

/ / Non Diabetic Division Members. The cost of our newsletter on tape is $5. This is tax-deductible and will go to the National Federation of the Blind.

PLEASE PRINT:

Name:____

Address:______________________________________

City:__________________State:____________Zip:_______

**Send this application to: Ed Bryant, Editor, The Diabetic Support Network,
111-A N. Stadium Blvd. #162, Columbia, Missouri 65203**

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Address Change Form

If you have moved or we have your address wrong or have in some other way fouled up this mailing, please let us know.

Print your name and address as it appears on the newsletter:

Name:____

Address:______________________________________

City:__________________State:____________Zip:_______

Print your correct name and address:

Name:____

Address:______________________________________

City:__________________State:____________Zip:_______

**Send this form to: Karen Mayry, President, The Diabetic Division of NFB, 919 Main, Suite 15,
Rapid City, S.D. 57701**

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The Diabetic Division of the National Federation of the Blind Board Member Listing:

Karen Mayry, President
919 Main, Suite 15
Rapid City, S.D.
57701

Eileen O'Brien, Vice-President
791 Cambridge
Elmhurst, IL
60126

Ed Bryant, 2nd Vice President
111-A N. Stadium Blvd. #162
Columbia, MO
65203

Patty Arocho, Secretary
80 N. Moore, Apt. 4K
New York, NY 10013

Carl Nimis, Treasurer
125 Oak Grove St., Apt. 105
Minneapolis, MN 55403

For Diabetic Division Membership

The South Dakota State Library sends, at no charge, a cassette tape of our newsletter publication. The only requirement is that **you must return the tape or you will not be sent another.**

In order to help keep costs down, if we do not hear from you, it will be assumed that you wish to receive your newsletter on cassette tape only. After all, we want to spend as little of your money on printing as we can.

Please check one:

_______ I would like to receive my newsletter in print form only.
_______ I would like to receive my newsletter on tape only
_______ I would like to receive my newsletter **both** in print and on tape.

PLEASE PRINT:
Name:____

Address:____

City:____________________State:______________Zip:__________

Send this application to: Karen Mayry, President, The Diabetic Division of NFB, 919 Main, Suite 15, Rapid City, S.D. 57701

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Application and/or Information Request

The Diabetic Division of the National Federation of the Blind. We are a diabetic support network with much expertise and knowledge in dealing with diabetes. If you would like to join our network or simply desire more information, please check the appropriate box.

/ / I wish to become a member at large of the Diabetic Division of the National Federation of the Blind. Enclosed is $1.00 payable to "The National Federation of the Blind". I understand that these yearly dues entitle me to receive The Diabetic Support Network in print and/or a cassette tape. I understand that cassette tapes must be returned.

/ / I do not wish to join your organization at this time but would like to receive additional information regarding The Diabetic Support Network and the National Federation of the Blind.

/ / I do not wish to join your organization but would like to receive a newsletter 4 times yearly. The cost of the newsletter is approximately $6.00, and bearing that in mind, I am enclosing a donation payable to "The National Federation of the Blind" to help cover the costs of publishing this newsletter.

PLEASE PRINT:
Name:____

Address:____

City:______________________State:______________Zip:__________

Telephone Number:____________________

Send this application to: Karen Mayry, President, The Diabetic Division of NFB, 919 Main, Suite 15, Rapid City, S.D. 57701